

THE IMPACT OF BEHAVIORAL HEALTH TRAINING IN PRIMARY CARE SETTINGS

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### **Abstract**

In 2016, the Institute for Education in Healthcare (IEH) at Rhode Island College (RIC) created a behavioral health curriculum that has since evolved into a comprehensive behavioral health certificate program. The program aims to educate primary care paraprofessional employees in behavioral health competencies to improve their capability when interacting and caring for patients with behavioral health issues. While paraprofessionals often care for patients with behavioral health needs, they receive little to no formal training in behavioral health. This study evaluates the effectiveness of a behavioral health certificate program for primary care paraprofessionals. The certificate program provided training to 93 paraprofessionals employed by a Federally Qualified Health Center in Rhode Island, Thundermist Health Center. After completing the training, participants received a behavioral health certificate and a 2% increase in salary. Post-training feedback forms were completed by the participants to self-report their level of behavioral health knowledge and self-efficacy before and after the training. The post-training feedback form also allowed the participants to report on their level of satisfaction with the certificate program. The instructors completed a presentation feedback form to assess each participant's knowledge and self-efficacy gains demonstrated during their final presentations. Data analysis showed that participants had significant knowledge and self-efficacy gains pertaining to behavioral health and had high satisfaction with the certificate program. This program evaluation provides evidence that behavioral health training can be an effective intervention to bolster the primary care paraprofessional workforce in caring for those with behavioral health needs.

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### **Introduction**

In the United States, behavioral health care has been a key component in health reform due to the increasing number of individuals who suffer from behavioral and mental health issues. In 2019, 20.6% of adults in the U.S. experienced some form of mental illness. 18.4% of those adults also experienced a substance use disorder (SUD) (National Alliance on Mental Illness, n.d.) In Rhode Island, adults with some form of mental illness increased from 160,000 in 2019 to 178,000 in 2021 (Hellebuyck et al., 2018). Furthermore, 74,000 Rhode Islanders currently suffer from a SUD (Mental Health America, 2021). In 2019, prior to the COVID-19 pandemic, one in ten adults in the United States claimed to have symptoms of anxiety or depression (Kaiser Family Foundation, 2020). Unfortunately, behavioral health issues have surged during the COVID-19 pandemic widening the gap in the unmet need for behavioral health care. The Household Pulse Survey was created to measure the mental health impact of the pandemic and recorded the percentages of individuals experiencing symptoms of anxiety or depression in 12-day increments. From April 23, 2020, to May 5, 2020, 34.4% of adults in Rhode Island reported experiencing symptoms of anxiety or depression (U.S. Census Bureau, 2020-2021).

Aside from the increasing behavioral health needs due to the COVID-19 pandemic, research indicates that Rhode Island does not have adequate resources in community-based services, particularly with the behavioral health workforce in Federally Qualified Health Centers (FQHC) (Rhode Island Senate, 2017). One in five Americans suffer from a behavioral health disorder (National Alliance on Mental Illness, n.d.) and roughly two-thirds of people with mental health care needs do not receive adequate care (Kilbourne et al., 2018). More often than not, primary care practices are the first point of contact for those who need behavioral health services (American Hospital Association, 2019). As the unmet need for behavioral health care increases

in Rhode Island, staff shortages for direct care workers occur. The shortage of health care workers along with the absence of behavioral health knowledge among staff prevents high-quality care for those with behavioral health needs. Testimonials of health care professionals included in the Rhode Island Senate report claim that better care coordination between care managers, physicians, and other providers is needed to improve outcomes and remove barriers to behavioral health care (Rhode Island Senate, 2017). A method to improve care coordination and reduce the unmet need of behavioral health care is to ensure employees working in a primary care setting are knowledgeable about behavioral health. To reduce barriers and improve patient care, the Rhode Island Department of Health (2017, p. 14) has identified the following methods to improve overall health care:

- Assist in connecting individuals of need to disease prevention resources.
- Optimize early interventions and referrals to improve care in the early stages of disease rather than the late stages of disease.
- Utilize patient navigation to improve physical and behavioral health outcomes.
- Integrate physical and behavioral health.

While these methods show the importance of linking behavioral and physical health to optimize patient care, it fails to address the process of care integration and how to effectively strengthen the workforce to have the capacity to integrate the two. To integrate physical and behavioral health, it is pertinent that health care professionals are knowledgeable in disciplines such as behavioral health.

In efforts to integrate care, many primary care providers have transitioned to a more holistic approach to health care that aims to provide whole-person care which recognizes a

patients' needs beyond physical health. This approach to care addresses a broader spectrum of patient needs related to the determinants of health such as medical, behavioral, socioeconomic, etc. (California Association of Public Hospitals and Health Systems, 2021). Whole-person care addresses all of the factors that contribute to overall health and well-being while also removing barriers to care. To provide whole-person care, behavioral health needs to be addressed at a primary care level. To ensure high-quality care for those with behavioral health needs, various care models have been introduced in primary care settings to integrate behavioral and physical health.

A Patient Centered Medical Home (PCMH) is one example of a care model that aims to improve health care by improving the way primary care is organized and delivered (Agency for Healthcare Research and Quality (AHRQ), n.d.a). This model of care has been implemented in over 13,000 practices across the United States (National Committee of Quality Assurance, 2019). A PCMH seeks to improve the delivery of primary care by ensuring a practice delivers five core functions. These functions include: comprehensive care through a team-based approach to meet a patient's physical and mental health care needs; patient-centered care; coordinated care to aid in an efficient transition across the care continuum; increased accessibility for patients by reducing wait times, extending office hours, etc.; and providing safe and high-quality care by using evidence-based care and decision making and measuring performance to improve quality of care (AHRQ, n.d.a).

Warm handoffs have been adopted into many primary care settings to improve behavioral health integration. A warm handoff is a type of care transition for patients with behavioral health care needs that helps streamline care among the care team. This transition is performed between two health care professionals in front of the patient. During this time, the health care

professionals and the patient discuss the diagnosis and care plan to encourage patient engagement and transparency (AHRQ, n.d.b).

These models of care that have been implemented into primary care settings help the integration process but challenges still exist. Although primary care providers often interact with patients that have behavioral health needs, providers are not typically specialized in behavioral health (Beck et al., 2019). Aside from providers, other frontline workers in these settings, such as medical assistants, patient services representatives, etc. encounter patients who have behavioral health issues. These paraprofessionals receive little to no formal training on how to interact and care for those with behavioral health needs. Lacking knowledge regarding the signs and symptoms of mental illness and SUD may result in paraprofessionals being ill-equipped to meet the need of this patient population. Unfortunately, failure to recognize and effectively communicate with a patient that has behavioral health needs, such as mental health disorders and SUDs, often occurs due to the lack of provider training (Kilbourne et al., 2018). Providing the workforce with resources such as behavioral health training can bolster workers' capabilities in interacting with and caring for patients.

This research evaluated the effectiveness of a behavioral health certificate program dedicated to paraprofessionals in a primary care setting, specifically in a FQHC. This study hypothesizes that behavioral health training will improve primary care paraprofessionals' capabilities to properly engage and care for patients with behavioral health issues.

The specific aims of the study were to:

1. Assess the changes in participants' knowledge of behavioral health and behavioral health care after the training

2. Assess the changes in participants' self-efficacy in caring for patients with behavioral health needs after the completion of the training
3. Assess the participants' satisfaction with the behavioral health certificate program.

### **Background and Significance**

The Institute for Education in Healthcare (IEH) at Rhode Island College (RIC) convened healthcare providers to identify the educational needs of their workforce. The need for behavioral health training for paraprofessionals surfaced as a top priority. IEH then coordinated with clinicians and health care managers from organizations across the continuum of health care to identify specific training needs. These training needs helped to inform the design of the 30-hour behavioral health curriculum that was created by RIC faculty from the psychology department and the school of social work.

This research evaluated the training provided to paraprofessionals employed by a large FQHC, Thundermist Health Center, with locations in Woonsocket, West Warwick, and Wakefield, Rhode Island. As stated by Thundermist Health Center (2019) the mission is “To improve the health of our patients and communities by delivering exceptional health care, removing barriers to that care, and advancing healthy lifestyles.” Thundermist is a PCMH that focuses on highly-coordinated care that is tailored based on each patient's needs to remove barriers and provide whole-person care. The wide range of services offered includes primary care, medication-assisted treatment (MAT), chronic disease management, trans health access, women's health, behavioral health care, and more. In 2019, Thundermist cared for roughly 51,000 patients. Compared to previous years, there has been a 22% increase in patients who need MAT services and a 34% increase in patients who need trans health care. Thundermist has nearly



7,000 patients who utilize the behavioral health services totaling in over 40,000 visits in 2019 (Thundermist Health Center, 2019).

The patient population consists of roughly 19% Hispanic, 64% White, 7% Black or African American, 3% Asian, and 1% American Indian or Alaskan Native (Thundermist Health Center, 2019). Thundermist Health Center is committed to having a racially diverse staff to accommodate their patient population. Many patients of Thundermist Health Center struggle with homelessness, SUD, and unemployment which stresses the importance of frontline workers understanding the core competencies of behavioral health.

Thundermist Health Center's model of physical and behavioral health integration utilizes multidisciplinary teams to coordinate care across the continuum. This team consists of behavioral health case managers, behavioral health clinicians, psychiatric clinical nurse specialists and prescribers, psychiatrists, peer recovery specialists and coaches, and site supervisors. The use of these teams helps to streamline care to effectively meet the needs of each patient. Each team member brings a different discipline and skill set to effectively plan and manage care. Behavioral health referrals are conducted through warm handoffs. Warm handoffs occur when a clinician identifies a behavioral health need or a patient is in crisis during a scheduled visit or contacts the health center by telephone. For a patient to be referred to behavioral health, they must be an existing primary care patient at Thundermist Health Center. Thundermist management recognized that paraprofessionals at the health center, such as patient services representatives, community health workers, medical assistants, and outpatient navigators, encounter patients with behavioral health needs but they do not have the knowledge or skill to meet the patients' needs.

Training requirements for primary care paraprofessional roles such as patient services representatives, community health workers, medical assistants, and outpatient navigators were reviewed to further justify the need for behavioral health training and to determine if these positions required any behavioral health-related training. It was found that specialized behavioral health training is not offered or required for any of the paraprofessional positions. Current training for roles as a patient services representative, community health worker, and medical assistant include similar training topics such as patient and customer service skills, ethical responsibilities such as patient confidentiality and HIPAA, and administrative skills including the usage of electronic medical records systems. Additional clinical training for medical assistants includes topics such as basic pharmacology, anatomy, physiology, and basic safety and infection control. In contrast, outpatient navigators do not need any type of certification or training to qualify for the role. Primary care paraprofessionals experience first-hand encounters with patients who suffer from behavioral health issues. However, they do not receive any training on how to interact and care for those patients. Behavioral health education and training is a crucial component of workforce development to appropriately care for the patient population. To improve the quality of care and the competencies of the paraprofessional workforce, Thundermist made a commitment to train paraprofessional employees in the IEH behavioral health certificate program and rewarded the achievement of this certification with a 2% increase in salary.

Thundermist Health Center offered the behavioral health certificate program to incumbent paraprofessional employees. To be an eligible participant in the certificate program, employees had to be a paraprofessional with a job title such as medical assistant, patient services representative, outpatient navigator, or community health worker. The announcement of the

training at the health center was met with great enthusiasm as 140 paraprofessionals showed interest in participating. A total of 93 participants completed the 30-hour in-person behavioral health certificate program in 2019-2020. Four in-person trainings were offered with four different instructors. The trainings took place at RIC and the health centers in Woonsocket, Wakefield, and West Warwick. Cohort One consisted of 28 participants and took place at RIC from November 16<sup>th</sup>, 2019 to February 8<sup>th</sup>, 2020. Cohort Two had 39 participants and took place at the health center located in West Warwick from November 16<sup>th</sup>, 2019 to December 28<sup>th</sup>, 2019. For Cohorts One and Two, classes were split into five-hour sessions for six weeks. Cohort Three had nine participants and took place at the health center located in Wakefield from November 18<sup>th</sup>, 2019 to January 13<sup>th</sup>, 2020. Cohort Four had 17 participants and took place at the health center located in Woonsocket from November 19<sup>th</sup>, 2019, and ended on February 11<sup>th</sup>, 2020. Cohorts Three and Four held classes in three-hour sessions for ten weeks. The last assignment in order to successfully complete the certificate program included a final presentation. For each cohort, the last two classes were utilized for participants to present their final project. Since Cohort Three was a smaller class, the nine participants finished their presentations on January 13<sup>th</sup> and the last class, originally scheduled for January 20<sup>th</sup>, was canceled.

Professional development through the certificate program aimed to increase behavioral health knowledge, sensitivity, and to prepare staff to meet the needs of patients with behavioral health issues to enhance performance in patient care. The behavioral health certificate program was intended to demonstrate best practices and build awareness around the challenges and concepts of behavioral health at a primary care level. The core competencies of behavioral health were organized into five modules that were taught throughout the program.

## **Curriculum**

### *Module 1: Introduction to Behavioral Health and Integrated Care*

The first part of the behavioral health training introduced students to behavioral health concepts, challenges, and how to apply best practices in the workplace. This introductory section educated the participants about the meaning of behavioral health; the relevance of behavioral and mental health; and why integrated behavioral health produces improved health outcomes.

### *Module 2: Disorders: Signs and Symptoms*

The second module introduced an assessment technique called the 4 D's of abnormality (Deviance, Dysfunction, Distress, and Danger) that can help providers detect signs of abnormal behavior. The section also dived deeper into the prevalence, symptoms, and treatments of behavioral and mental health disorders including anxiety, depression, post-traumatic stress disorder (PTSD), dementia, schizophrenia, addiction, and suicide. As there are different behavioral and mental health disorders, care approaches, intervention, and treatment vary. Frontline workers must be able to distinguish between different behavioral health conditions to provide proper care to the patient.

### *Module 3: Addiction and Screening, Brief Intervention, and Referral to Treatment*

Module three of the training program reviewed the five Stages of Change, Motivational Interviewing (MI), the biological explanation of addiction, and how to use the DSM 5 criteria for a SUD, which is used in care settings to determine the severity of a SUD. Screening, Brief Intervention, and Referral to Treatment (SBIRT) was also introduced in this section as an integrated model that frontline workers can utilize that encourages routine screening as a preventative measure for mental health disorders or SUD. Other screening tools were explained such as the Alcohol Use Disorder Identification Test (AUDIT), Single Item Drug Question, Drug

Abuse Screening Test (DAST-10). Teaching these screening tools and concepts provided frontline workers with the knowledge to support prevention and intervention through evidence-based practices.

#### *Module 4: Professional Communication*

The ability to act professionally in a health care setting promotes patient safety and can improve patient satisfaction. This module explored the elements of active listening, ethics, and boundaries, as well as taught de-escalation and crisis intervention techniques. As frontline workers spend most of their time caring for others, it is important to find a balance to ensure they are also caring for themselves. This module also discussed the importance of self-care and self-reflection for health care workers to promote a healthy work-life balance and improve overall job performance. Teaching these types of skills assists frontline staff in effectively performing their job duties within contexts where patients have behavioral and mental health disorders.

#### *Module 5: Culture and Context Awareness*

The last module of the behavioral health training aimed to sensitize frontline workers to diversity in the workplace and with patients who present behavioral health issues. Concepts such as cultural competence and disparities in health care were introduced to the participants to increase their level of empathy, patience, and self-knowledge. To provide patient-centered care, cultural competence and context awareness are key factors to ensure a patient is being cared for in a way that aligns with their beliefs and values. For an outline of the behavioral health certificate program, please see Appendix A.

### **Review of Literature**

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health is defined as the promotion of mental health and well-being and the treatment of any mental health disorder or SUD (Substance Abuse and Mental Health Services Administration, n.d.). Not only is it important to address a behavioral health disorder on its' own but behavioral health disorders are known to be linked to higher rates of morbidity and mortality making it a public health issue (Hausleiter et al., 2020). Addressing behavioral health at a primary care level can be used as a strategy to improve overall population health. However, primary care professionals do not have the skill set or knowledge to provide care for the patient population.

In 2015, Rhode Islanders between 18-24 years old were more likely than any other New England state to have serious psychological distress (Truven Health Analytics, 2015, p. 15). Furthermore, nearly 8% of Rhode Islanders between 25-64 years old lived with depression in 2017. Out of the 8% living with depression, roughly 5% also have a serious mental illness (Rhode Island Department of Health, 2017). As for older adults, 13.5% of Rhode Islanders have some form of mental illness and roughly 6% suffer from SUD or alcoholism (Rhode Island Department of Health, 2017). Through the prevalence rates of behavioral health disorders in Rhode Island, it shows a need for primary care professionals to be competent in behavioral health in order to care for the patient population. To improve competency around behavioral health, behavioral health training for paraprofessionals could be a beneficial tool to better interact, recognize, and understand patients in order to address and manage their behavioral health care needs.

Many primary care practices function as the first point of contact for patients who require behavioral health services (Huggard, 2020). In 2010, a study revealed that nearly 20% of primary care visits included at least one type of mental health indicator varying from a depression screening to a mental health diagnosis (Centers for Disease Control and Prevention, 2014). Data collected from 2012 through 2014 revealed that out of 30 million mental health-related office visits, 32% of these visits were conducted by a primary care physician (Centers for Disease Control and Prevention, 2018). Additional health issues can co-occur or result from a behavioral or mental health issue making it crucial that primary care workers have the ability to care for a patient with behavioral health needs. Roughly 68% of adults with a mental health disorder have at least one medical condition and about 30% of adults with a medical condition have a behavioral health disorder (Druss & Reisinger Walker, 2011; American Hospital Association, 2019). Often having these comorbid problems can worsen both conditions if not properly managed. For instance, an individual with depression not only has a higher risk for developing a heart condition but is also two to five times more likely to have severe chest pain, a heart attack, or a stroke in the next year compared to those who do not suffer from depression (Rhode Island Department of Health, 2017, p. 90). Data shows a correlation between certain mental illnesses and behavioral health issues with alcohol/tobacco use, obesity, asthma, high blood pressure, high cholesterol, diabetes, cardiovascular disease, strokes, and early death (Rhode Island Department of Health, 2017, Substance Abuse and Mental Health Services Administration, n.d.). Since many patients in primary care settings with pre-existing medical conditions are more likely to have behavioral health issues, behavioral health knowledge among health care staff is crucial.

While patients with behavioral health needs in primary care settings is increasing, health care workers remain unprepared and uneducated in effectively serving this population. Providers

vary in their skill set to accurately diagnose a patient with behavioral health issues and often show a lack of confidence when addressing a patients' behavioral health needs (Huggard, 2020). Research shows that primary care providers play a major role in the delivery of behavioral health services which needs to be considered when optimizing patient care.

In 2019, researchers at the University of Michigan Behavioral Health Workforce Research Center conducted a study that involved 313 primary care physicians. These physicians were asked to complete a survey to evaluate physician medical specialty and practice characteristics, patient population characteristics, physician practices for screening and diagnosing patients for behavioral health disorders, and roles in managing patients with behavioral health disorders. The results revealed that when primary care physicians were asked about their confidence level towards treating mental or behavioral health disorders, the confidence level varied by the disorder. Physicians reported a high level of confidence in their ability to treat patients with depression, anxiety, and ADHD. However, most physicians reported low levels of confidence in their ability to treat patients with a serious mental illness or a SUD. When screening patients for a SUD, only 43% claimed to use a validated addiction screening tool. If a provider feels unprepared or uncomfortable caring for a patient with a mental or behavioral health disorder, it can influence the provider's habits when carrying out treatment or prescription plans. One factor that contributes to the lack of confidence in treating mental and behavioral health disorders is inadequate behavioral health education and training (Beck et al., 2019). Given that workers in primary care deal with nearly a third of mental health-related office visits (Centers for Disease Control and Prevention, 2018), it shows that awareness and knowledge regarding behavioral health is a necessity to interact and care for a patient.



The lack of behavioral health training for primary care professionals negatively impacts patients with behavioral health needs. Without behavioral health training present, patients with underlying behavioral health needs could be misdiagnosed or undiagnosed when in a primary care setting. This problem contributes to why roughly one in eight Emergency Department visits involves a behavioral health condition (American Hospital Association, 2019). Findings show that Rhode Island has the highest hospitalization rate for mental disorders and SUD compared to neighboring New England states such as Maine, Massachusetts, and Vermont (Truven Health Analytics, 2015, p. 18). Hospitalizations and emergency room visits can often be prevented if the patient is receiving sufficient care from their provider. Unfortunately, many patients experience difficulty receiving behavioral health care because of funding allocation for behavioral health services. A majority of the behavioral health funding is spent towards inpatient care rather than preventative community behavioral health services, which leaves a shortage of outpatient care and treatment due to financial hardships (Jennings et al., 2019). As a result, patients are not receiving the behavioral health care they need in primary care settings. A way to optimize patient care while lowering health care costs through reduced hospitalizations is to redirect funding towards evidence-based practices that focus on community-based prevention, early intervention, and treatment outcomes that will ultimately aid in the improvement of care coordination (Truven Health Analytics, 2015, p. 22). By pivoting to preventative and early intervention care while also providing adequate training to health professionals, patients are more likely to receive the proper care at a primary care level and less likely to be hospitalized.

Existing literature has shown the impact of behavioral health training and education can improve the primary care workforce's ability to care for those with behavioral health needs. One study evaluated an evidence-based online training called *At-Risk Primary Care*. This online

training aimed to assist primary care providers to improve their ability to screen patients for behavioral health issues and to conduct MI to encourage patients to change their health behaviors. The training course consists of an online simulation created by Kognito and was accepted into SAMHSA's National Registry of Evidence-Based Programs and Practices. The study included 877 participants and took place from December 2014 through June 2018. The job roles of the participants who completed this training included physicians, nurses, nurse practitioners, mental health professionals, medical/nursing students, and others. The study evaluated the course based on the participant's completion of a baseline survey, a post-intervention survey, and a 90-day follow-up survey. By reviewing the three surveys given to the participants, it was found that from the baseline survey to the post-intervention survey and 90-day follow-up survey, increases related to knowledge and skills contributed to the overall preparedness of participants. Participants revealed an increased capacity to identify risk factors, warning signs, and symptoms of a mental health disorder or SUD. Participants also reported an increase in their ability to screen patients for behavioral health issues using evidence-based practices; to more comfortably discuss options for harm reduction and treatment options with patients; and to build motivation in patients for them to adhere to treatment. The results also showed that the participants who completed the online training course were more likely to screen patients and manage treatment for patients with a mental health disorder or SUD. To assess behavior change and referral rates, participants were asked to record the number of patients over two months who were screened, engaged in brief intervention, or referred a patient to treatment for a mental health disorder or SUD. From the baseline to the 90-day follow-up, screenings increased by 139.8%, brief interventions increased by 84.5%, and referrals for treatment increased by 48.3%. Aside from the increase in knowledge and skills from this online training

course, participants reported very high ratings for the learning experience. Out of the participants that completed the course, 95% stated that they would recommend the training course to their colleagues and 93% reported that the course enhanced their knowledge or skills as a healthcare provider (Albright & Adam, 2018).

A study conducted in Ethiopia by Ayano et al. (2017) evaluated the effectiveness of mental health training for primary care professionals. This study aimed to improve the knowledge, attitude, and skill set of non-specialized professionals in primary care to improve mental health services in a primary care setting. This quasi-experimental pre-and-post study design was conducted in 2016 and included 94 primary care professionals who completed the training. Primary care professionals in this study consisted of nurses and health officers. The training course was taught by psychiatry professionals using a standardized guide aimed to improve mental health care in a primary care setting. The training focused on four disorders which included alcohol use disorder, depression, psychosis, and epilepsy. The pre-and-post assessment forms measured knowledge, attitude, and practice from each of the four disorders. The results showed that there were significant improvements in knowledge, attitude, and practice pertaining to the four disorders. The pre-and-post data for knowledge of the professionals increased by 53% for psychosis, 43% for depression, 19% for epilepsy, and 54% for alcohol use disorders. Likewise, attitude increased by 55% for psychosis, 40% for depression, 36% for epilepsy, and 44% for alcohol use disorders. Lastly, when measuring the case identification rate, results showed an increase of 63% for psychosis, 55% for depression, 21% for epilepsy, and 41% for alcohol use disorders (Ayano et al., 2017). This study further confirms that mental health training is a critical component to improve knowledge, attitude, and practice which supports behavioral health integration into primary care, as well as improves the overall quality of care.

A similar study was conducted in England to review a mental health workshop for occupational health practitioners. The responsibilities of occupational health practitioners include advising employees and employers on individuals' return-to-work programs after an injury or accident so they must be competent in recognizing common mental health issues. This research was organized to evaluate the effectiveness of a one-day workshop that aimed to improve the knowledge and confidence of occupational health practitioners in identifying and managing depression, anxiety, suicide risk, and substance/alcohol use disorder. Although occupational health care differs from primary care, both disciplines work to prevent, diagnose, and treat illness. Furthermore, this study can be used to support the effectiveness of behavioral health training for health care workers. The behavioral health training consisted of one six-hour workshop with a maximum of 35 students in each class. The curriculum was created by occupational consultants who were experienced psychiatrists and physicians, along with help from a senior lecturer in medical education. During the workshop, participants engaged in lectures, group discussions, and problem-based cases. All participants were given a workshop manual for reference. The six topics taught in this workshop included the assessment and management of patients with depression, anxiety, suicide risk, and substance/alcohol use disorder. To determine the impact of this workshop on occupational health practitioners, three pieces of data were collected. This included an evaluation that was given before the workshop began. This evaluation collected the demographic information along with information on previous training, knowledge, attitude, and confidence in assessing and managing patients with behavioral health needs. A second evaluation was administered immediately after the workshop and questioned the participants on learner satisfaction and their knowledge, confidence, and attitude gained from the training. A final evaluation occurred four months post-workshop to

determine if the participating health professionals could apply their professional development in the workplace after the training. Each evaluation was in the form of a 1-7 point scale (a score of 1 meant highly dissatisfied and a score of 7 meant highly satisfied). Altogether, the overall satisfaction with the workshop was very high. 100% of the participants reported their satisfaction level to be between 5-7 points on the scale. The second evaluation showed that a majority of participants had improved levels of confidence in all of the six topics taught in class. It also showed knowledge gained from the workshop reflected in their day-to-day clinical practice. The 4-month post-workshop evaluation showed significant changes in clinical practice after attending the training. The most significant improvement in knowledge, confidence, and attitude gains occurred in practitioners that had never participated in a mental health-related training course (Madan et al., 2013). Training and education in mental and behavioral health appear to be effective for multidisciplinary groups regardless of their education, level of experience, and previous training.

In the specific role of a medical assistant (MA), responsibilities include orienting patients to their visits, taking vital signs, administering screening forms, collecting specimens, etc. Since MAs are a point of contact for the patient, they can encourage patient engagement and communication. A study conducted by Brown et al. (2013) piloted a communication training for MAs in pediatric primary care. The initial pilot took place in an FQHC that predominantly serves a Latino population. The pilot aimed to determine if the training was an effective tool in facilitating behavior changes of MAs toward patients with mental and behavioral health care needs. The framework of the training course was derived based on the Gateway Provider Model (GPM) which aimed to reduce barriers to improve the communication and information flow from the patient to the provider. This model intended to improve the facilitation in identifying and

treating behavioral health issues. The training educated participants on topics including motivational enhancement, patient activation interventions, and family therapy. The training sessions occurred in three one-hour sessions over the course of six weeks and included activities such as group discussions, videos, and role-play. The study investigated whether the material learned in the training improved MAs' communication skills in ways that increased the likelihood of the parents' willingness to discuss their child's mental health concerns with the provider. By MAs changing their communication style as a result of the communication training, parents were more willing to discuss mental health issues after the training. Before the training, only 67% of parents agreed that they should discuss their child's feelings and behaviors with the MA. After the training, the percentage of parents that felt they should discuss their child's feelings and behaviors with the MA increased to 91%. Given the opportunity to participate in this training, many MAs claimed an increase in the ability to help families feel comfortable during their visit and an increase in preparedness to respond (Brown et al., 2013).

Acknowledging that behavioral health should be present in primary care settings has altered the perceived role of paraprofessionals according to a study that investigated the evolving role of a MAs. A study by Fraher et al. (2021) set out to explore MAs roles as new workflows are created to transfer additional tasks over to MAs to reduce the burden on a physician to avoid burnout. Through May and September of 2017, a survey was administered to MAs and family physicians in primary care practices. As an incentive to complete the survey, MAs and family physicians that completed the survey were eligible for a \$100 gift card. The survey consisted of questions regarding the frequency of different tasks performed, areas in which MAs believe additional training would be helpful, and expectations of MAs according to the physicians. The response rate of those who completed the survey included 118 MAs and 175 family physicians.

59% of MAs in this study claimed that they have experienced a change in job duties since starting their current position. New tasks delegated to MAs include MI, screening for behavioral health issues, goal setting, patient education, etc. When MAs were surveyed, they reported being less confident in their ability to conduct MI, goal setting, and patient education. Furthermore, when physicians were surveyed, they reported low levels of confidence in the MAs ability to perform such tasks. The study revealed that physicians were more likely to increase their level of confidence in MAs to perform these tasks if adequate training and education were available to them (Fraher et al., 2021).

While reviewing the existing literature, there were few studies conducted in the United States that evaluated behavioral health education and training for paraprofessionals in primary care settings. There is a need for research in this area to determine an effective intervention technique to train primary care paraprofessionals in behavioral health. Behavioral health training for health care workers encourages the transfer of knowledge from the content taught in class into real-life interactions with patients. It can help educate and enhance self-efficacy in the staff to utilize evidence-based approaches and patient engagement techniques to provide high-quality care. As primary care is often the first point of contact for those who may need additional health services, primary care staff play a critical role in ensuring that patient needs are addressed, in which behavioral health competency is necessary.

## **Methodology**

### **Study Design**

This study evaluated the behavioral health certificate program provided to paraprofessionals at Thundermist Health Center to:

1. Assess the change in participants knowledge of behavioral health and behavioral health care after the training.
2. Assess the change in participants self-efficacy in caring for patients with behavioral health needs after the completion of the training.
3. Assess the participants' satisfaction with the behavioral health certificate program.

This study was granted exemption from Rhode Island College's Institutional Review Board due to the use of secondary data and minimal risk to the participants. The forms that were analyzed in this study were anonymous with no identifying factors. The certificate program was evaluated in two ways. The first was to analyze a post-training feedback form that was completed at the end of the training. All participants completed the post-training feedback form in which they self-reported their levels of behavioral health knowledge and self-efficacy before the training and after the training. The post-training feedback form was also used to analyze the participants' levels of satisfaction with the program. The second measure focused on knowledge and self-efficacy gains and included analyzing a final presentation feedback form. This form was completed by the instructor and used to assess the participants' transfer of training knowledge to their work in the field.

### **Measurement Instruments**

Data used for this study included demographic information for all participants, post-training feedback forms completed by each participant, and presentation feedback forms completed by the instructor for each participant who completed the behavioral health certificate program.



On the first day of the behavioral health certificate program, demographic forms were distributed to each participant. The information that was collected included race, ethnicity, gender, and education level. The IEH collected this information to determine the population of participants that enrolled in the certificate program. For this study, the demographic information was used to determine if the participant population reflected the general population of the human services workforce in Rhode Island. The demographic form can be viewed in Appendix B.

On the last day of training, all students were required to complete an evaluation form that was distributed by the instructor. The IEH created the post-training feedback form to determine if the program increased knowledge around behavioral health and improved participants' abilities to care for patients with behavioral health needs. This feedback was used to assess knowledge and self-efficacy gains upon completion of the program and to assess the participants' satisfaction with the certificate program. The first section of the post-training feedback form included 13 multiple choice questions pertaining to knowledge and self-efficacy. Each participant reported on their levels of knowledge and self-efficacy from before they started the program and after they had completed the program. Please note that there was not a pre-test administered before the training to measure participants' pre-training knowledge and self-efficacy. The post-training feedback form was a self-assessment post-test in which participants were able to gauge their prior knowledge and self-efficacy around behavioral health and compare it to post-training gains. The survey responses were based on a 1-4 scale. A one represented a low level of knowledge or self-efficacy while a four represented a high level of knowledge or self-efficacy. To analyze this data, each question was sorted into one of two groups based on whether the question related to the participants level of knowledge or self-efficacy. Questions regarding the participants' understanding and/or awareness of the behavioral health concepts

corresponded with knowledge (i.e. *I have a clear understanding of what behavioral health is and/or I am aware of the stigma that is often associated with behavioral health illnesses*).

Questions regarding the participants' confidence and/or abilities to apply behavioral health concepts into their work corresponded with self-efficacy (i.e. *I am confident in my ability to care for a client with a mental health disorder*). Once sorted, there were a total of seven knowledge-related questions and six self-efficacy-related questions. Additional questions concerning the likelihood to apply behavioral health concepts into their work and community as well as the participants' satisfaction with the training were also based on a 1-4 scale. For this section of questions on the post-training feedback form, a one represented strongly disagree, a two represented disagree, a three represented agree, and a four represented strongly agree. The post-training feedback form can be found in Appendix C.

A final presentation was required for all participants to receive the behavioral health certification and wage increase. The purpose of the final presentation was to have participants reflect and utilize the material taught in the training and relate the concepts to a past situation or encounter they have experienced. The final presentation required a 10-15 minute oral presentation with the optional use of a PowerPoint. Participants discussed a previous interaction with a client where they had applied skills that were taught in the certificate program or reflected upon an experience where they could have handled a situation differently based on the content that was learned in the certificate program. After each presentation, the instructor completed a presentation feedback form for each participant to indicate their level of knowledge and understanding of behavioral health. The final presentation feedback form included three multiple-choice questions. The feedback form was broken down into three components in which the instructor rated on a 1-3 scale.

1. Clear and concise delivery (Q1)
2. Application and demonstration of competencies (Q2)
3. Shared helpful hints, tips, and/or strategies during the training (Q3)

Four values were used to measure each question in the data set, zero represented no response, one represented did not meet expectations, two represented that the expectations were met, and three meant expectations were exceeded. Instructors completed the form after each participant's presentation. The final presentation feedback form can be found in Appendix D.

### **Analytical Approach**

To present the demographic information based on cohort, descriptive statistics in SPSS were utilized. From these statistics, averages were calculated and used to determine if the participant population was an accurate representation of the human services workforce. Tests were performed using IBM SPSS Version 26 to compare each cohort's pre and post-training knowledge and self-efficacy scores recorded on the post-training feedback form. The label "pre-training post-test score" indicates the participants' response in the post-training feedback form that assessed prior knowledge and self-efficacy before the training. The label "post-training post-test score" indicates the participants' responses in the post-training feedback form that assessed knowledge and self-efficacy gains after the training was completed. The letter "K" was used to indicate a knowledge-related question and the letter "C" was used to indicate questions that related to self-efficacy. To code the responses in SPSS, a zero indicated the absence of a response. The values one, two, three, and four were used to indicate the scores that were recorded on the scale. The mean scale scores for each of the pre-training and post-training questions were evaluated for the significance of difference using the non-parametric Wilcoxon test. Since the four cohorts varied in class size, this test was chosen because it makes fewer

assumptions about the distribution. For each of the four cohorts, 13 tests were performed that included responses pertaining to knowledge and self-efficacy.

Descriptive statistics analyzed the additional questions regarding workplace and community application of behavioral health concepts and the degree of satisfaction with the certificate program. The six questions were based on a 1-4 scale. In SPSS, the values one, two, three, and four indicated the scores that were recorded on the scale. The value zero was used to indicate no response. To analyze the presentation feedback forms from the four cohorts, descriptive statistics were used to summarize the findings from each of the three rubric components.

## **Results**

A total of 93 participants completed the behavioral health certificate program. Out of which 93 (100%) demographic forms, 82 (88%) post-training feedback forms and 92 (98.9%) presentation feedback forms were completed and used in the analysis. To determine if the participant population was an accurate representation of the Rhode Island human services workforce, demographic statistics of all cohorts were calculated and are displayed in Table 1. Results from the post-training feedback form which measured knowledge gains, self-efficacy gains, and satisfaction are organized by cohort and can be viewed in Tables 2-13. Results from the presentation feedback forms are also organized by cohort and are displayed in Tables 14-17.

### **Demographic Information**

The 2020 report by Bryant University's Hassenfeld Institute for Public Leadership was reviewed in this study to determine the population of the human services workforce in Rhode Island. This report states that females comprise 80% of the human services workforce, which surpasses the 49.86% of females in the general workforce. The racial diversity of the human

services workforce in Rhode Island is made up of 65% White, 18% Hispanic or Latino, 12% Black, and 5% other, with roughly 4% of these workers unable to speak English well. In 2018, it was recorded that women in Rhode Island make 84 cents to every dollar a man makes and people of color are less likely to be promoted to management positions or make over \$50,000 as a human services worker. For instance, out of the 65% of White people working in this sector, 86% have a yearly salary over \$50,000 while only 7% of Black people make over \$50,000. The human services workforce appears to have more financial hardships than those in the general workforce. On average, a worker in this sector makes \$26,258.65 per year. As for education levels, 8% have completed less than high school, 23% have completed high school or equivalent, 33% have completed some college, 23% have completed a bachelor's degree, and 13% have completed an advanced degree (Sullivan, 2020). These statistics revealed disparities in the workforce that result in further marginalization on pay such as gender and race although education levels are similar to those in the general workforce. The behavioral health certificate program gave the incumbent paraprofessionals at Thundermist Health Center the opportunity to improve their behavioral health knowledge while also receiving a wage increase, which assists in reducing the pay gap for the human services workforce. The demographic statistics for the four cohorts are displayed below.

**Table 1**

*Demographic Statistics*

Demographic Categories	Cohort One	Cohort Two	Cohort Three	Cohort Four	Average (All cohorts)
<b>Race:</b>					
White	50.0%	59.0%	100.0%	35.3%	61.1%
Asian	3.6%	7.7%	0.0%	5.9%	4.3%
Black/African American	14.3%	7.7%	0.0%	23.5%	11.4%
American Indian/Alaska Native	3.6%	0.0%	0.0%	0.0%	.9%

Native Hawaiian/other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%
Prefer not to answer	28.6%	25.6%	0.0%	35.3%	22.4%
Other	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Ethnicity:</b>					
Non-Hispanic/Latino (any race)	35.7%	64.1%	88.9%	58.8%	61.9%
Hispanic/Latino (any race)	53.6%	33.3%	11.1%	41.2%	34.8%
Prefer not to answer	10.7%	2.6%	0.0%	0.0%	3.3%
<b>Gender:</b>					
Female	100.0%	89.7%	100.0%	100.0%	97.4%
Male	0.0%	7.7%	0.0%	0.0%	1.9%
Non-binary/Gender nonconforming	0.0%	0.0%	0.0%	0.0%	0.0%
Prefer not to answer	0.0%	2.6%	0.0%	0.0%	.7%
Other	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Education:</b>					
No high school	3.6%	0.0%	0.0%	0.0%	.9%
GED	0.0%	5.1%	0.0%	11.8%	4.2%
High school diploma	3.6%	7.7%	11.1%	5.9%	7.1%
Some college, no diploma	32.1%	35.9%	22.2%	29.4%	29.9%
Associate degree	17.9%	5.1%	11.1%	11.8%	11.5%
Bachelor's degree	17.9%	17.9%	11.1%	11.8%	14.7%
Master's degree	0.0%	2.6%	0.0%	0.0%	.7%
Trade/technical/vocational training	25.0%	15.4%	11.1%	11.8%	15.8%
Certificate program	0.0%	0.0%	0.0%	0.0%	0.0%
Prefer not to answer	0.0%	10.3%	33.3%	17.6%	15.3%
Other	0.0%	0.0%	0.0%	0.0%	0.0%

According to the data, individuals who identify as female and white account for the majority of the human services workforce and the participant population. Data also shows various education levels ranging from not completing high school to having an advanced degree appear in both populations. According to the averages collected from the participants in all cohorts, the sample consists of a more diverse population since on average, 34.8% of individuals that were in the certificate program identified as Hispanic compared to only 18% reported in the human services workforce in Rhode Island.

### Post-training Feedback Forms

The results from performing a Wilcoxon test revealed that when measuring the level of knowledge before and after the training, all cohorts showed statistically significant changes that

provided sufficient evidence to reject the null hypothesis. Knowledge-related questions not only touched upon overall knowledge of behavioral health, but also the importance of prevention, the connection between physical and mental health, the stigmatization that is often associated with behavioral health illnesses, and MI. Results also indicated that all four cohorts had statistically significant changes in the level of self-efficacy. Self-efficacy-related questions consisted of measuring a participant's confidence or ability to take care of a patient with a mental health disorder or SUD, reduce interpersonal conflict regarding a patient, utilizing concepts such as effective listening, empathy, coping skills, and a strength-based approach towards the patient. The additional questions included in the post-training feedback form reveal that nearly all participants reported a high level of satisfaction with the certificate program and agreed that the material taught in the program can be useful in their work.

### *Cohort One Results*

The results displayed for Cohort One revealed that the post-training score means increased when compared to the pre-training score means for knowledge-related and self-efficacy-related questions. All p-values in this data set were reported as .000, which validates that knowledge and self-efficacy gains were present immediately after the behavioral health certificate program ended.

**Table 2**

### *Cohort One Knowledge Questions*

Questions (knowledge)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
K1	2.38	3.81	.000
K2	2.05	3.90	.000
K3	2.24	3.62	.000
K4	2.14	3.71	.000
K5	2.48	3.76	.000

K6	2.10	3.95	.000
K7	1.90	3.86	.000

\*p < .05.

**Table 3**

*Cohort One Self-efficacy Questions*

Questions (self-efficacy)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
C1	2.05	3.67	.000
C2	1.95	3.38	.000
C3	2.29	3.90	.000
C4	2.24	3.81	.000
C5	2.19	3.71	.000
C6	2.48	3.90	.000

\*p < .05.

As shown in Table 4, 100% of the participants in Cohort One recorded that they strongly agree with the statements, *Overall, I am satisfied with the training I received and I would recommend this training to my colleagues.* All participants agreed or strongly agreed with the statements listed in Table 4.

**Table 4**

*Cohort One Satisfaction Questions*

Statements	No Response	Strongly Disagree	Disagree	Agree	Strongly Agree
This training will help me to use new approaches and/or strategies in my work/community.	---	---	---	14.3%	85.7%
The training will make a difference in how much I work with consumers and/or other stakeholders.	---	---	---	14.3%	85.7%
I am confident in my ability to apply the information gained in this training.	---	---	---	23.8%	76.2%



Overall, I am satisfied with the training I received.	---	---	---	---	100%
I would recommend this training to my colleagues.	---	---	---	---	100%
How likely are you to apply the information from the training to your work?	---	---	---	9.5%	90.5%

**Cohort Two Results**

Cohort Two yielded similar results to Cohort One. All p-values among pre-training and post-training means equaled .000. Since the P-value is less than .05 for all knowledge-related and self-efficacy-related questions, Cohort Two provided additional support to accept the hypothesis.

**Table 5**

*Cohort Two Knowledge Questions*

Questions (knowledge)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
K1	2.61	3.86	.000
K2	2.33	3.61	.000
K3	2.53	3.86	.000
K4	2.58	3.86	.000
K5	2.89	3.94	.000
K6	2.36	3.75	.000
K7	2.33	3.67	.000

\*p < .05.

**Table 6**

*Cohort Two Self-efficacy Questions*

Questions (self-efficacy)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
C1	2.36	3.44	.000
C2	2.31	3.56	.000
C3	2.58	3.69	.000
C4	2.58	3.81	.000
C5	2.22	3.61	.000

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C6	2.75	3.78	.000
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\*p < .05.

In Cohort Two, data shows that one person (2.8%) did not respond to the statements, *This training will help me to use new approaches and/or strategies in my work/community, the training will make a difference in how much I work with consumers and/or other stakeholders and I am confident in my ability to apply the information gained in the training.* Aside from the participant who did not respond to three of the questions, the remainder of participants agreed or strongly agreed with each of the statements displayed in Table 7.

**Table 7**

*Cohort Two Satisfaction Questions*

Statements	No Response	Strongly Disagree	Disagree	Agree	Strongly Agree
This training will help me to use new approaches and/or strategies in my work/community.	2.8%	---	---	5.6%	91.7%
The training will make a difference in how much I work with consumers and/or other stakeholders.	2.8%	---	---	25.0%	72.2%
I am confident in my ability to apply the information gained in this training.	2.8%	---	---	16.7%	80.6%
Overall, I am satisfied with the training I received.	---	---	---	13.9%	86.1%
I would recommend this training to my colleagues.	---	---	---	16.7%	83.3%
How likely are you to apply the information from the training to your work?	---	---	---	11.1%	88.9%

---

*Cohort Three Results*

The results shown for Cohort Three reaffirmed the previous findings in Cohort One and Two. Cohort Three results confirmed that the pre-training score means and post-training score means significantly changed to further support that the behavioral health certificate program impacted knowledge and self-efficacy levels.

**Table 8***Cohort Three Knowledge Questions*

Questions (knowledge)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
K1	2.78	3.67	.000
K2	2.33	3.33	.000
K3	2.22	3.44	.000
K4	2.00	3.22	.000
K5	2.33	3.67	.000
K6	2.33	3.67	.000
K7	2.44	3.56	.000

\*p < .05.

**Table 9***Cohort Three Self-efficacy Questions*

Questions (self-efficacy)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
C1	2.44	3.44	.024
C2	2.22	3.33	.004
C3	2.00	3.33	.010
C4	2.11	3.33	.005
C5	2.22	3.33	.007
C6	3.00	3.78	.008

\*p < .05.

As seen in Table 10, when participants in Cohort Three provided feedback on the certificate program, all participants agreed or strongly agreed with the six statements. An overwhelming majority of participants who answered these questions in the post-training

feedback forms demonstrated a high level of satisfaction with the program. Additionally, participants reported that the material taught was deemed helpful in the workplace and community.

**Table 10**

*Cohort Three Satisfaction Questions*

Statements	No Response	Strongly Disagree	Disagree	Agree	Strongly Agree
This training will help me to use new approaches and/or strategies in my work/community.	---	---	---	33.3%	66.7%
The training will make a difference in how much I work with consumers and/or other stakeholders.	---	---	---	44.4%	55.6%
I am confident in my ability to apply the information gained in this training.	---	---	---	44.4%	55.6%
Overall, I am satisfied with the training I received.	---	---	---	22.2%	77.8%
I would recommend this training to my colleagues.	---	---	---	11.1%	88.9%
How likely are you to apply the information from the training to your work?	---	---	---	11.1%	88.9%

*Cohort Four Results*

Lastly, Cohort Four results revealed that the means recorded pertaining to the level of knowledge and self-efficacy before the training was notably lower than levels after the training. All p-values were reported to be less than .05, which confirms that each cohort showed statistically significant changes in knowledge and self-efficacy gains when compared to before and after the training.

**Table 11**

*Cohort Four Knowledge Questions*

Questions (knowledge)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
K1	2.37	3.94	.001
K2	2.31	3.87	.001
K3	2.63	3.94	.001
K4	2.38	3.62	.003
K5	2.81	3.81	.006
K6	2.81	3.94	.003
K7	2.13	3.63	.001

\*p < .05.

**Table 12**

*Cohort Four Self-efficacy Questions*

Questions (self-efficacy)	Post-test pre-training score (mean)	Post-test post-training score (mean)	P-value
C1	2.31	3.69	.001
C2	2.13	3.56	.001
C3	2.75	3.75	.001
C4	2.44	3.69	.001
C5	2.19	3.75	.001
C6	3.13	4.00	.014

\*p < .05.

The results from Cohort Four displayed in Table 13 provide similar results to the other three cohorts. Participants agreed or strongly agreed on the statements pertaining to the satisfaction with the certificate program and the transfer of knowledge from the classroom to their workplace.

**Table 13**

*Cohort Four Satisfaction Questions*

Statements	No Response	Strongly Disagree	Disagree	Agree	Strongly Agree
------------	-------------	-------------------	----------	-------	----------------

This training will help me to use new approaches and/or strategies in my work/community.	---	---	---	6.3%	93.8%
The training will make a difference in how much I work with consumers and/or other stakeholders.	---	---	---	12.5%	87.5%
I am confident in my ability to apply the information gained in this training.	---	---	---	12.5%	87.5%
Overall, I am satisfied with the training I received.	---	---	---	6.3%	93.8%
I would recommend this training to my colleagues.	---	---	---	6.3%	93.8%
How likely are you to apply the information from the training to your work?	---	---	---	12.5%	87.5%

Results from the four cohorts validated that the certificate program's objectives to increase behavioral health knowledge and ability to enhance patient care were met. Based on the results from the Wilcoxon test, participants who completed the program demonstrated an overall improvement in knowledge and self-efficacy immediately post-training. These gains were further supported since nearly all of the participants agreed or strongly agreed to being able to utilize the new material taught in the program in their workplace and in the community. High levels of satisfaction with the certificate program are shown across all four cohorts. Additionally, all participants reported that they would recommend the training to their colleagues.

Results show that when participants compared their levels of knowledge before and after the training, Cohort One revealed the most significant changes in the majority of the knowledge-related statements in the post-training feedback form. The statements in which Cohort One demonstrated the most significant changes were, *I have a clear understanding of the different*

*types of behavioral health disorders, I have a clear understanding of how mental health and physical health are linked, I understand that behavioral health disorders are usually not obvious to the caretaker, I have a clear understanding of why prevention is important for behavioral health, and I have a clear understanding of motivational interviewing.* Cohort One also showed the most significant changes in the majority of the statements about self-efficacy. These statements included, *I am confident in my ability to care for a client with a mental health disorder, I am confident in my ability to care for a client with a substance use disorder, I am confident in my ability to reduce interpersonal conflict regarding a patient, I am confident in my ability to use a strengths-based care approach to patients, and I am confident in my ability to listen to patients with empathy.* Out of the four cohorts, Cohort Three revealed the biggest change in the knowledge-related statement, *I am aware of the stigma that is often associated with behavioral health illnesses.* In Cohort Four, one of the knowledge-related questions stating, *I have a clear understanding of what behavioral health is* demonstrated the most significant knowledge gains out of the four cohorts. Cohort Four shared the same results as Cohort One when comparing the training score means of self-efficacy gains pertaining to the statement, *I am confident in my ability to care for a client with a substance use disorder;* and *I am confident in my ability to help patients with coping skills* appeared to have the greatest pre and post-training change in Cohort Four. When analyzing the data collected from the post-training feedback forms, Cohort Two showed statistically significant improvements in knowledge and self-efficacy gains but did not show the greatest change in pre and post-training gains in any of the 13 questions when compared to the other cohorts. Furthermore, Cohort 3 had the least amount of pre and post-training changes in the statements, *I have a clear understanding of what behavioral health is* and *I am confident in my ability to listen to patients with empathy.*

A very high level of satisfaction with the behavioral health certificate program was conveyed across the four cohorts. Although all four cohorts agreed or strongly agreed for all questions pertaining to the overall satisfaction with the course, differences were identified when comparing the cohorts. In Cohort One, 100% of participants strongly agreed with the statement, *Overall, I am satisfied with the training I received*, meanwhile, only 77.8% of participants in Cohort 3 strongly agreed. Additionally, 100% of the participants in Cohort One strongly agree with the statement, *I would recommend this training to my colleagues*. Even though every participant agreed or strongly agreed with both, *Overall, I am satisfied with the training I received* and *I would recommend this training to my colleagues*, Cohort One appeared to have the highest ratings in these statements when compared to the other cohorts. In Cohort Three, 55.6% of participants strongly agreed and 44.4% agreed with the statements, *The training will make a difference in how much I work with consumers and/or other stakeholders* and *I am confident in my ability to apply the information gained in this training*. Conversely, Cohorts One, Two, and Four demonstrated higher satisfaction concerning those two statements, showing that at least 72.2% of participants within these cohorts reported they strongly agreed with the two statements. High satisfaction with the certificate program show that participants found the training useful and reconfirms the need of specialized behavioral health training for paraprofessionals in primary care.

## **Presentation Feedback Forms**

### ***Cohort One Results***

Table 14 shows that out of the 28 participants in Cohort One, all participants met or exceeded the instructor's expectations during the final presentation in each of the three rubric components.



**Table 14***Cohort One Presentation Feedback Form*

Rubric Component:	No Response		Does not meet		Meets		Exceeds	
	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Delivery of Presentation	0.0%	0	0.0%	0	51.7%	15	44.8%	13
Application of Competencies	0.0%	0	0.0%	0	51.7%	15	44.8%	13
Shared Helpful Tips/Strategies	0.0%	0	0.0%	0	65.5%	19	31.0%	9

***Cohort Two Results***

In Cohort Two, there were a total of 39 participants. As displayed in Table 15, all participants met or exceeded the instructor's expectations in the delivery of the presentation and shared helpful tips and strategies. Although the majority of the participants met or exceeded expectations when getting evaluated on the application of competencies, the data showed that there was one missing response from an instructor.

**Table 15***Cohort Two Presentation Feedback Form*

Rubric Component:	No Response		Does not meet		Meets		Exceeds	
	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Delivery of Presentation	0.0%	0	0.0%	0	50.0%	19	50.0%	19
Application of Competencies	2.6%	1	0.0%	0	39.5%	15	57.9%	22
Shared Helpful Tips/Strategies	0.0%	0	0.0%	0	39.5%	15	60.5%	23

***Cohort Three Results***

Cohort Three was the smallest sized cohort with only nine participants. Table 16 shows that while 77.8% of the participants met expectations, 11.1%, or one participant, exceeded expectations. When reviewing the overall delivery and sharing helpful tips and strategies during the presentation, 11.1% of one participant did not meet the instructor's expectations. In the

second rubric component, application of competencies, the data showed that there was one missing response from an instructor.

**Table 16**

*Cohort Three Presentation Feedback Form*

Rubric Component:	No Response		Does not meet		Meets		Exceeds	
	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Delivery of Presentation	0.0%	0	11.1%	1	77.8%	7	11.1%	1
Application of Competencies	11.1%	1	0.0%	0	77.8%	7	11.1%	1
Shared Helpful Tips/Strategies	0.0%	0	11.1%	1	77.8%	7	11.1%	1

***Cohort Four Results***

Cohort four consisted of 17 participants and showed that all participants who presented either met or exceeded the instructors expectations. Table 17 reveals that a majority of the participants appear to have met expectations in all three components of the rubric.

**Table 17**

*Cohort Four Presentation Feedback Form*

Rubric Component:	No Response		Does not meet		Meets		Exceeds	
	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Delivery of Presentation	0.0%	0	0.0%	0	52.9%	9	47.1%	8
Application of Competencies	0.0%	0	0.0%	0	64.7%	11	35.3%	6
Shared Helpful Tips/Strategies	0.0%	0	0.0%	0	70.6%	12	29.4%	5

The data provided in the final presentation feedback forms showed that an overwhelming majority of the 93 participants demonstrated improved knowledge and ability to transfer training concepts to their work in a primary care setting. Cohort Two was the only cohort in which the majority of participants exceeded the instructor's expectations in the three rubric components. In

the other cohorts, the majority of participants met the instructors' expectations. With that being said, Cohort Three reported that 11.1% (one person) did not meet expectations in the delivery of the presentation and sharing helpful tips and strategies. The feedback collected from the final presentations support the hypothesis that the behavioral health certificate program can improve the level of knowledge and self-efficacy in paraprofessionals.

### **Discussion**

This program evaluation suggests that the behavioral health certificate program is an effective intervention to improve behavioral health knowledge and self-efficacy in primary care paraprofessionals. The results from this study yielded similar to those found in the existing literature. Previous studies have revealed that behavioral health training and education improve health care workers' levels of knowledge, attitude, skill set, and confidence. However, the samples used in those studies only included health professionals such as nurses, nurse practitioners, occupational health practitioners, physicians, health officers, mental health professionals, and medical/nursing students. Existing literature shows that as behavioral health needs increase, the health care workforce remains inadequately trained to care for the increasing number of patients with underlying behavioral health issues. This study shares new insight on how behavioral health training can strengthen the capability of paraprofessionals' interactions with and caring for those with behavioral health needs in a time where these services are greatly needed.

### **Limitations**

Although this study offers new insight on behavioral health training for the paraprofessional discipline in primary care, there are limitations in this study to be considered. While 93 participants completed the program, only 82 post-training feedback forms and 92

presentation feedback forms were collected. The lack of feedback forms completed could have occurred due to a participant's absence on the last day of class or could have been misplaced during the collection process. However, the other pieces of data used in the study serve as reinforcement to support the overall strength of the results that the certificate program provided knowledge and self-efficacy gains for paraprofessionals.

The second limitation concerns the effectiveness of the behavioral health training over time. In the existing literature, many of the studies conducted a follow-up evaluation months after the participants completed the training. However, the IEH did not administer a follow-up survey to the participants. Originally, the IEH intended to administer a supervisor evaluation to receive feedback from the supervisor staff at Thundermist Health Center regarding the impact of the certificate program on Thundermist employees. Towards the end of the certificate program, the shutdown due to the COVID-19 pandemic occurred. As a result, Thundermist had a temporary shutdown which prevented the supervisor evaluation forms from being distributed.

Findings indicate that each cohort showed significant knowledge and self-efficacy gains. However, inconsistencies exist in the characteristics between each cohort such as the class size and the instructor. The class sizes in this study varied. For example, Cohort Three had 9 participants and Cohort Two had 39 participants. The results show that when evaluating pre and post-training knowledge and self-efficacy gains, Cohorts One and Four had the most significant changes in the majority of questions pertaining to knowledge and self-efficacy. Perhaps due to the small class size of Cohort 3, group discussions were inhibited due to there being only nine participants. On the other hand, Cohort Two had the largest cohort which could have also made group discussions more difficult. Ultimately, having a class size too small or too large could have impacted participants' knowledge and self-efficacy gains pertaining to the group discussion

aspect of the class. The larger class size was due to the overwhelming interest and availability of the participants of when they could attend class. This uneven distribution in class size could have potentially skewed the results. For example, in a small cohort such as Cohort Three, one person was equivalent to 11.1% of the total participants. In the case of Cohort Two being much larger than Cohort Three, one person was only equivalent to roughly 2.6% of the total participants. Additionally, since each cohort had a different instructor, it is possible that participants in each cohort had a different experience in the program which could cause inconsistencies in participant reporting.

### **Recommendations for Future Research**

For future research on the effectiveness of behavioral health training, it is recommended that feedback forms be completed in order to receive their certificate and wage increase. When conducting in-person training, it should be required that before the participants leave the classroom, all required paperwork should be completed and handed in to the instructor. Doing so will ensure that each participant completes the necessary documentation and will strengthen the results of a future study.

Although the results from this study show knowledge and self-efficacy gains immediately after the training, a post-training follow-up for participants is recommended in future studies. A post-training survey for participants would assess their knowledge and self-efficacy gains overtime after the completion of the training. Post-training surveys may provide insight to determine the longevity of the workforce development gains from the behavioral health certificate program. Post-training feedback could help in determining if a one-time behavioral health training is sufficient or if the behavioral health training should be offered on a reoccurring basis.

A supervisor evaluation is also recommended in order to confirm that knowledge and self-efficacy gains surrounding behavioral health are present in the workplace. This type of evaluation could also be used as an improvement tool for future behavioral health trainings. Receiving feedback from health care supervisors could help enhance the behavioral health curriculum by including additional behavioral health concepts that supervisors suggest would be useful in primary care settings.

Lastly, the program could be improved by synchronizing each cohort so every participant has the same learning experience. This could include an even distribution of class size by offering additional class times of the certificate program or offering the certificate program through an online platform in hopes to increase accessibility to those who would be unable to attend an in-person class. In addition to reduce the inconsistencies among cohorts in the future, it would be recommended that the different instructors convene to discuss the curriculum and delivery of the certificate program and ensure that the classes are in sync to make sure each participant is receiving the same experience throughout the certificate program.

### **Conclusion**

This study revealed the positive impact that behavioral health training has on paraprofessionals working in a primary care setting, specifically FQHC's. More specifically, this research has discovered that among the four cohorts that participated in the behavioral health certificate program, all cohorts exhibited immediate post-training gains in knowledge and self-efficacy. All cohorts included in this study reported a high level of satisfaction with the training and a strong likelihood that the training would positively impact their performance in the workplace and the community. Behavioral health training is proven to be a vital tool to bolster the primary care workforce in interacting, managing, and caring for patients with behavioral

health needs. This study provides additional support and highlights the need for behavioral health training in primary care, not only for clinical staff but for all front-line health care workers that interact with patients. To further investigate the impact of behavioral health training on primary care paraprofessionals, it is recommended that a post-training survey and supervisor evaluations be administered to further investigate the short-term and long-term impact of behavioral health education and training.

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## Appendix A

### Behavioral Health Certificate Program Curriculum

This 30-hour Behavioral Health training introduces front-line staff to behavioral health concepts, professional communication, common disorders and a variety of contexts in which behavioral health vulnerabilities may occur, and Screening Brief Intervention and Referral to Treatment (SBIRT). The overall goal of this training is for front-line staff to develop a useful awareness of behavioral health to inform their approach to their work responsibilities within healthcare contexts.

**1: Introduction to Behavioral Health & Integrated Care** (8 hours). Provides front-line staff with an orientation to behavioral health including challenges, concepts and workplace application.

Part One (4 hrs.)

- What is Behavioral Health?

Part Two (4 hrs.)

- Understanding Behavioral Health Concepts: Prevention, Treatment & Recovery
- Bringing Integrated Behavioral Health Awareness to Work

**2: Disorders: Signs & Symptoms** (5 hours) An introduction of front-line staff to behavioral health disorders commonly found within health care and community contexts.

- A. Connecting Physical and Behavioral Health
- B. Anxiety, Stress & Trauma
- C. Mood Disorders & Suicidality
- D. Neurocognitive Disorders
- E. Dementia
- F. Schizophrenia
- G. Co-Occurring Disorders
- H. Introduce Student Projects/Presentations

**3: Addiction** (2 hours) and SBIRT (Two hours)

SBIRT: Students will learn how to implement the SBIRT intervention in a generalized healthcare setting. Students will understand how to conceptualize a clinical case study using SBIRT, understand how to use multiple screenings tools (CAGE, DAST-10, ASSIST, & CRAFFT), how to conduct a Brief Negotiated Interview (BNI), and understand the basic principles of Motivational Interviewing.

**4: Professional Communication** (5 hours). Provision of professional communication skills that will assist front-line staff in conducting their work within contexts where people may present significant behavioral vulnerabilities.

- A. Active Listening
- B. Self-Reflection
- C. Crisis Management & De-escalation
- D. Boundaries
- E. Ethics

- F. Communication with the Care Team
- G. Students updates on project/presentation ideas and discussion with peers

**5: Culture & Context Awareness** (4 hours). Sensitizing front-line staff to the importance of considering the diversity of contexts in which behavioral health disorders may be present.

- A. Characteristics of context & culture
- B. Behavioral health disparity factors
- C. Culture in healthcare contexts
- D. Cultural competence

**Part 6: Application & Integration** (4 hours). Facilitating the application and integration of course concepts and skills. This includes presentation, peer review, and discussion of individual student projects.

**Learning Goals:** As a result of participation in this training students will demonstrate:

1. Understanding of the connections between psychology and health.
2. Awareness of behavioral health challenges and repercussions.
3. Understanding the importance of behavioral health integration within the workplace
4. Familiarity with prevention, treatment and recovery concepts.
5. Ability to communicate with the care team.
6. Ability to assist people in locating professional behavioral health help and information.
7. Understanding of professional boundaries and ethics.
8. Ability to recognize, address and regulate unproductive biases or emotional states.
9. Ability to use active listening skills.
10. Competency in crisis management and de-escalation.
11. Ability to recognize the basic characteristics/presentation of behavioral health disorders.
12. Recognition of the capacities and vulnerabilities that people with behavioral health disorders may have.
13. Sensitivity to the co-occurring (interrelated) nature of behavioral health disorders.
14. Ability to comprehend the connection between physical and behavioral health.
15. Ability to recognize the basic characteristics/presentation of behavioral health disorders.
16. Sensitivity to the importance of diverse behavioral health contexts.

**Appendix B**

## Demographics Form

1. Name  
\_\_\_\_\_
2. Date of Birth (mm/dd/yyyy)  
\_\_\_\_\_
3. Email address  
\_\_\_\_\_
4. Mailing address  
\_\_\_\_\_
5. What is your race? (select all that apply)
  - White
  - Asian
  - Black/African American
  - American Indian/Alaska Native
  - Native Hawaiian/other Pacific Islander
  - Prefer not to answer
  - Other: \_\_\_\_\_
6. What is your ethnicity?
  - Hispanic
  - Non-Hispanic
  - Prefer not to answer
7. To what gender do you most identify?
  - Female
  - Male
  - Non-binary/Gender nonconforming
  - Prefer not to answer
  - Other: \_\_\_\_\_
8. What is your highest level of education? (check all that apply)
  - No high school
  - GED
  - High school diploma
  - Some college, no diploma
  - Associate degree
  - Bachelor's degree
  - Master's degree
  - Trade/Technical/Vocational Training
  - Certificate program
  - Prefer not to answer



Other: \_\_\_\_\_

**Appendix C**

Post-training Feedback Form

Please read the statements below to reflect on your level of understanding before and at the end of training. Using the table and the corresponding scale, where 1 represents a low level of understanding and 4 represents a high level of understanding.

- Using the left column, circle the number that best represents your level of understanding of each of the training’s learning objectives before the training.
- Using the right column, circle the number that best represents your level of understanding of each of the training’s learning objectives at the end of the training.

Date completing the evaluation: \_\_\_\_\_

Which Cohort? (Please check only one box)

- Cohort 1- Rhode Island College
- Cohort 2- West Warwick
- Cohort 3- Wakefield
- Cohort 4- Woonsocket

<b>Impact of Training on Your Level of Understanding</b>		
	<b>Before the training:</b>	<b>After the training:</b>
I have a clear understanding of what behavioral health is.	1 2 3 4	1 2 3 4
I am confident in my ability to care for a client with a mental health disorder.	1 2 3 4	1 2 3 4
I have a clear understanding of the different types of behavioral health disorders.	1 2 3 4	1 2 3 4
I am confident in my ability to care for a client with a substance use disorder.	1 2 3 4	1 2 3 4
I have a clear understanding of how mental health and physical health are linked.	1 2 3 4	1 2 3 4
I understand that behavioral health disorders are usually not obvious to the caretaker.	1 2 3 4	1 2 3 4
I am aware of the stigma that is often associated with behavioral health illnesses.	1 2 3 4	1 2 3 4
I am confident in my ability to reduce interpersonal conflict regarding a patient.	1 2 3 4	1 2 3 4

I am confident in my ability to use a strengths-based care approach to patients.	1 2 3 4	1 2 3 4
I have a clear understanding of why prevention is important for behavioral health.	1 2 3 4	1 2 3 4
I have a clear understanding of motivational interviewing.	1 2 3 4	1 2 3 4
I am confident in my ability to help patients with coping skills	1 2 3 4	1 2 3 4
I am confident in my ability to listen to patients with empathy	1 2 3 4	1 2 3 4
<b>Training Feedback Content</b>		
Please circle the number that best represents your level of agreement with each statement below. 1= Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree		
The objectives for the training were clear.	1 2 3 4	
The training focused on important content.	1 2 3 4	
The training introduced new material for me.	1 2 3 4	
There was a good mix of theory and practical application in the training.	1 2 3 4	
The difficulty level of the training was appropriate for my skill level.	1 2 3 4	
<b>Training Feedback Facilitation</b>		
The trainer was well prepared	1 2 3 4	
The trainer's background, experience, and/or expertise enhanced the quality of the session.	1 2 3 4	
<b>Training Feedback Application</b>		
The training used practical examples and activities to relate training concepts to my work.	1 2 3 4	
The training will help me to use my new approaches	1 2 3 4	

and/or strategies in my work/community.	
The training will make a difference in how I work with consumers and/or other stakeholders.	1 2 3 4
I can use the ideas, tools, and/or strategies presented in the orientation, without support.	1 2 3 4
I am confident in my ability to apply the information gained in this training.	1 2 3 4
<b>Training Feedback Experience</b>	
The facilities were suitable for training.	1 2 3 4
There was a climate of respect for participants' experiences, ideas, and contributions.	1 2 3 4
Overall, I am satisfied with the training I received.	1 2 3 4
I would recommend this training to my colleagues.	1 2 3 4
<b>Training Feedback Overall</b>	
How would you rate the overall quality of the training? (1=Poor, 4=Excellent)	1 2 3 4
How likely are you to apply the information from the training to your work? (1=Not at all likely, 4=Extremely likely)	1 2 3 4

Please describe how you plan to incorporate what you learned from this training into your work?

---

What are the 2-3 most important things you learned in the training?

---

In what way(s), if any, could the training be improved?

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Are there additional topics that you would like to learn more about?

- Yes
- No
- No response

If you answered “yes,” list additional topics below.

---

Please share any additional comments that you have about the training in the space below.

---

**Appendix D**

Presentation Feedback Forms

Clear and Concise Delivery	(Please circle) Does not meet Meets Exceeds
Clear and Concise Delivery Comments:	
Application/Demonstration of Competencies	(Please circle) Does not meet Meets Exceeds
Application/Demonstration of Competencies Comments:	
Shared Helpful Hints/Tips/Strategies During This Training	(Please circle) Does not meet Meets Exceeds
Shared Helpful Hints/Tips/Strategies During This Training Comments:	

Comments About the Presentation:

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